NHS
North Cumbria
Clinical Commissioning Group

NHS North Cumbria CCG Primary Care Commissioning Committee	Agenda Item
13 July 2017	8

Gain share 16/17– approval of GP practice funding

Purpose of the Report

The CCG agreed a "gain-share" arrangement in 2016/17 whereby a proportion of savings from reductions in prescribing and direct access diagnostics costs would be re-invested to pump prime changes in services, in line with "Healthcare for the Future, during 2017/18. The purpose of this report is to

- Seek approval for the investment of funds in General Practice
- Seek approval for a similar arrangement for 2017/18 for Integrated Care Communities (ICCs)

Outcome Required:	Approve	x	Ratify		For Discussion		For Information	

Assurance Framework Reference:

2, Better Care – Commission services that ensure the delivery if high quality and safe care for patients.
3, Sustainability – Commission services that ensure the delivery of high quality and safe care for patients in a manner that is sustainable for the whole health economy.
4, Leadership – The CCG needs to support its membership (i.e. general Practice) to provide high quality care to patients and support the delivery of safe, high quality financially sustainable health care services.

Recommendation(s):

The Primary Care Committee is asked to:

- Approve the proposals from Workington ICC
- Approve the ICC gain-share agreement for 2017/18

Executive Summary:

Key Issues:
Cumbria CCG operated a "Gain Share" Scheme during 2016/17 across all practices. This scheme provides funding in 2017/18 for groups of practices as ICCs based upon 40% of savings

generated in 2016/17 by underspending on their combined prescribing, pathology and radiology budgets. Indeed, it was noteworthy that underlying cost of prescribing reduced by around 3% in Cumbria during 2016/17. Six of the seven ICCs successfully underspent on their combined budgets contributing significantly to the CCG's cost improvement programme in 2016/17. Under the arrangements funds of £504,000 are available to spend by North Cumbria ICCs in 2017/18, on a non-recurring basis, as follows:

- Solway and Keswick - £106,555
- Workington - £70,143
- Carlisle - £177,312
- Copeland -£55,345
- Eden - £21,611
- Eden PCH - £73, 284

The ICCs have been provided with specific guidance on identification and prioritisation of initiatives for use of the funds. The management of these funds will be through the CCG's normal processes of budgetary approval and control. However, should some of the funding require specific payment for practices then approval of the Primary Care Committee is required to ensure that both the practice applies the funds in accordance with the approved guidelines and that the proposal represents value for money. To date, the only scheme submitted for consideration requiring consideration by the Primary Care Committee is from the Workington ICC that is shown as Appendix 1.

It also proposed, as noted in the report to June Finance & Performance Committee, to implement a similar arrangement for ICCs in North Cumbria that is shown at Appendix 2.

Key Risks:
There are clear rules established as to the application of the gain share and guidance has been issued to practices so risk is low. Further mitigation is provided in allowing the funds to be applied over a two-year period to enable optimal application.

Implications/Actions for Public and Patient Engagement:
The funds are intended to specifically "pump-prime" new initiatives for the benefit of patients.

Financial Impact on the CCG:
The CCG is covering the cost of the investment through uncommitted funds from the GP Quality Incentive Scheme in 2017/18.
The CCG has developed a Gain Share scheme for 2017/18 (Appendix 2) with the same principles so the funding would be available in 2018/19.

Strategic Objective(s) supported by this paper:	**Please select (X)**
Support quality improvement within existing services including General Practice	**x**
Commission a range of health services appropriate to Cumbria's Needs	x
Develop our system leadership role and our effectiveness as a partner	
Improve our organisation and support our staff to excel	

Impact assessment: (Including Health, Equality, Diversity and Human Rights)	N/A

Conflicts of Interest Describe any possible Conflicts of interest associated with this paper, and how they will be managed	Any CCG GP Clinical lead employed at a practice included in the proposal will not take part in the decision making process.

Lead Director	Caroline Rea
Presented By	Andrea Loudon
Contact Details	Andrea.loudon@northcumbriaccg.nhs.uk
Date Report Written	5 July 2017

Appendix 1

Gainshare Funding Proposal 2016/17

NHS North Cumbria Clinical Commissioning Group

ICC Name: Workington **Date Completed: 30 June 2017**

Practices Representing ICC: Beechwood, James St, Orchard House, Oxford St, Solway Health Services

Proposal	Resources & Costs	Lead	By When	Which ICC Objective does this support?	What outcomes do you hope to achieve?
Improving frail elderly care in Workington. Scheme supports practices in 2 ways: Supporting practices to fully and effectively implement GP contract requirements around frailty identification and management. Supporting practices with home / care home visits for frail elderly patients. Full details below.	Costed at FYC basis inc. on-costs: 22.5 hr nurse (Band 6) £26,600 Travel £1000 0.5 WTE admin (Band 3) £ 12,400 2 sessions pw GP time =£26,000	Workington Health Ltd / ICC manager On behalf of practices	To start immediately	Deliver more care outside of hospital Ensure an increased focus on prevention Ensure a more consistent approach to care planning/risk stratification Establish more efficient services with less waste	Support Workington practices to implement GP contract requirements around frailty identification and management. Provide additional capacity to GP practices through access to additional nurse support for home visits. Provide more time for individual patient home visits Reduce emergency admissions and A&E attendances Reduce number of ambulance conveyances Achieve better patient satisfaction with home visit assessment by improving patient, carer and family experience Provide support to community teams and ensure that skills are used more effectively

	TOTAL FYE =£65,000				Better outcomes for frail elderly patients- reduced falls, more appropriate medication, fewer admissions Practices working at scale

Additional Information

We recognise that the gainshare funding is non-recurrent yet we are applying for funding which is, in part, related to staffing costs. However, these staffing hours represent a temporary addition to hours of existing post-holders with the intention of allowing us to trial roles that we would anticipate forming part of an ICC. The gainshare funding will allow us to proceed at a more rapid pace and to trail the case finding, care planning and case management approach which we'd hope to see as part of the ICC. We have recognised that there is a significant amount of one-off work to establish frailty searches, reporting mechanisms, processes and this funding will allow us to support the establishment of this.

Background

Demand for urgent visits to FEAT team and community teams from practices and directly from care homes continues to rise. FEAT nurses who work closely with our care homes and know residents well, are often the most appropriate first point of contact for patients who require an acute visit (eg: off legs, general deterioration). However, it is clear that this urgent work and increasing 'one off' demands to visit patients in own homes detracts from FEAT's ability to undertake proactive work so this gainshare proposal suggests supplementing the FEAT 'urgent' service with further nurse hours and redefining role of the FEAT team to ensure that skills in assessment and treatment are used effectively to support practices with urgent management of the frail population as well as refocussing on the proactive, preventative role.

Urgent care/rapid response/support with home visits:

Additional Nurse hours will be provided by WHL to support practices with home visits. Each practice will continue to provide their own acute home visits but on receipt of a request for a home visit they will make the decision as to whether or not a practice GP needs to attend or whether it could be dealt with by the nursing team. In these cases the practice would pass on requests for home visits to ICC coordination hub.

Routing the request via the patient's own GP practice is important. The GPs know the patient and their circumstances and can make a safe decision about their needs and the appropriateness of their request. It also means that the patient has confidence in the decision about whether they should receive a visit as they have spoken to the practice with which they are registered and familiar. The FEAT nurse would be described as part of the practice team.

Following a visit the ANP/FEAT team will make an entry on to the patient notes within practice EMIS record.

Support with implementation of GMS contract requirements relating to frailty.

The 2017/18 GP contract requires practices to routinely undertake frailty identification for patients who are 65 or over. Practices will then be expected to then target and improve care and support for older people with the greatest need through early, proactive, targeted and appropriate interventions. It is proposed that the FEAT team's role is re-focussed to support practices and the ICC with this work.

The ICC coordination hub and FEAT team will work with practices to use Electronic Frailty index (eFI) to identify and manage patients aged 65 and over who are living with moderate and severe frailty. ICC hub will work with Practice Managers to set up a weekly risk stratification report (this work has already started). Hub will then analyse report on behalf of practices to produce a list identifying severely, moderately and mildly frail, plus those whose frailty score is changing.

The hub will create a practice dashboard to show all severely frail patients and patients whose frailty score is changing identifying whether they have:

- Care plan in place
- End of life plan in place
- Enriched summary care record in place
- Medication review in last 12 months
- Falls risk assessment in last 12 months
- Carers assessment in place
- Chronic disease review in last 12 months
- Fall in last 12 months
- Hospital admission in last 12 months

Where patients do not have an enriched summary care record the hub will create the relevant documentation for practices to issue to patients to seek this consent. Where plans are not in place or reviews have not been completed, the hub will schedule visits for FEAT team to complete.

The team will undertake an annual health and wellbeing check for severely frail housebound or care home residents to incorporate:

- Care plan
- End of life plan
- Enriched summary care record
- Medication review (supported by GP)
- Falls risk assessment
- Carer referral (where appropriate)
- Chronic disease review

The schedule for these annual visits will be created by the hub and in advance of the visit the patient will be contacted on behalf of the practice with information about the service and to encourage the patient and their carer to think about what they would like from the visit.

In the week preceding the visit a team member will undertake blood tests/ measurements to inform the assessment. (may not always be necessary if recent patient data is available) and the team will liaise with other teams who might be involved in the individual's care.

Sessional GP support will be provided to support with medication reviews and for complex individuals (particularly care home residents).

Following the visit the care plan will be updated on GP record and a summary of the consultation, including patient's health preferences and plans will be sent to the patient / carer.

KPIs

- No of acute visits undertaken
- Time spent on visits

Appendix 1

- Outcome of visits
- No. of hospital admissions following visit
- No. of admissions avoided (practitioner view)
- Number of Care plans/ End of life plans/ Enriched summary care records in place
- Medication reviews completed
- Falls risk assessment undertaken
- Referrals to carer support

NHS
North Cumbria
Clinical Commissioning Group

North Cumbria CCG Gain Share Scheme

For General Practice Prescribing and Diagnostic budgets 2017/18

1. Introduction

For 2016/17 NHS Cumbria CCG operated a Gain Share Scheme alongside the Quality Improvement Scheme (QIS).

NHS North Cumbria CCG will operate the scheme for 2017-2018. The aim of the scheme is to:

- ensure the best use of NHS resources by reducing waste within the system
- help achieve the required CCG financial balance
- stimulate the development of more collaborative working
- provide opportunity to shift the balance of resource in the system from acute to primary care

By offering a gain share arrangement it is envisaged that practices will have access to an additional source of funding for primary care investment and be rewarded for the effort involved in achieving those savings. In order to participate in the gain share agreement practices will be required to sign up to the QIS and be part of a larger group of practices working together – at a minimum as an Integrated Care Community. The proposal to award the primary care share of the funding to a group of practices rather than an individual practice care provides opportunity for practices to work collaboratively and share best practice as well as generating a more substantial reward. It also minimises the risk associated with historical budget setting and practice performance and practice size.

Prescribing

Prescribing costs has been included as part of the gain share because although we are historically a high performing CCG compared with the National and Northern averages, there are still practices and therapeutic areas showing considerable variation. There is also a well-established medicine optimisation team and an existing programme of initiatives to support with generation of savings.

Direct Access Pathology and Radiology Tests

The CCG has benchmarked the cost of direct pathology and has identified spend in excess of £4.5 million greater than average CCGs across both acute providers. The national average CCG spend per patient is less than £13 whereas Cumbria is around £21 per patient (Cumbria spends 1.6% of its budget on pathology compared to a median of 1%).

It is recognised that there may be a number of reasons for this, including the number of tests which practices perform on behalf of secondary care, however there is also significant variation between comparable practices which if reduced could generate savings through sharing of best practice and process review e.g:

- How practices organise the care of patients with long term conditions to minimise the number of duplicated tests.

- The development of practice protocols for standardising test requests.
- The inclusion of national guidelines on Map of Medicine.

There are also a number of IT solutions and education initiatives which could be developed to support a more uniform approach.

Feedback from secondary care suggests there is similar variation and savings to be released from radiological investigations.

2. Scope of scheme

2.1 Gain share scheme is only available to an agreed grouping of practices – at a minimum as an Integrated Care Community (ICC).

2.2 Gain share is only available to practices that are contractually committed to the CCG Quality Improvement Scheme (QIS).

2.3 Prescribing and Direct Access Pathology and Radiology Test budgets for 2017/18 are set on basis of agreed uplifts and cost improvements.

2.4 The gain share is for the savings to be apportioned 60% for CCG and 40% for the ICC of the budgetary underspend for the combined budgets of prescribing and direct access pathology and radiology tests, with payment being made to group for non-recurrent spend in 18/19. This split recognises the overall risk being held by North Cumbria CCG.

3. Governance arrangement

3.1. ICCs must be able to demonstrate that savings achieved are as a result of a planned programme of work agreed with the medicine optimisation and primary care development team.

3.2. ICCs should be aware of the following guidance for prescribing which includes some specific advice and principles to be adopted in framing and administering a prescribing incentive scheme.
e.g. "Strategies to achieve cost-effective prescribing: Guidance for Primary Care Trusts and Clinical Commissioning Groups (DH, 2010)" and Principles for sharing the benefits associated with more efficient use of medicines not reimbursed through national prices (NHSE, 2014)

Principles for sharing the benefits associated with more efficient use of medicines not reimbursed through national prices (NHSE, 2014).

3.3. Prescribing Initiatives must not compromise current supply and demand arrangements or jeopardise stock availability of drugs and appliances e.g. unplanned switches to branded generic preparations.

3.4. Activity and costs must not be transferred perversely to other parts of the healthcare system unless this is part of an approved framework or agreement.

3.5. The quality of prescribing and patient care must not be compromised and achievements must be made from appropriate changes in clinical behaviour.

3.6. The ICC is responsible for agreeing with practices within the group how rewards are utilised by the ICC.

4. Monitoring

4.1. Baseline from which assessment will be made will be 2017/18 budget for ICC prescribing and 2016/17 outturn for practice direct access pathology/radiology budgets.

4.2. National measure of quality of prescribing will be monitored and reported on quarterly to ensure overall quality of prescribing is not being compromised at ICC or practice level.

4.3. Practice and ICC financial prescribing performance and diagnostic performance will be monitored monthly. End of year adjustment may be made for significant "in-year" unforeseen changes and fluctuations outside practice, ICC and CCG control.
e.g. the following may be taken into account:

- Prescription Pricing Division pricing and coding errors
- Variation in high cost drug spend (in line with agreed high cost drug list)
- Significant changes in list size

4. ICC and practice level

4.1. The Primary care team, including the medicines optimisation team, will be available to support ICCs implement locally agreed schemes and provide practice level data to the ICC as required.

5. Financial Schedule

5.1 Gain share must be expended in 18/19 (or carried forward only with CCG agreement) on health care related activities/ equipment. A framework of approved uses can be found on page 6.

Approved Uses of cost savings

Gain share rewards should be spent following agreement by ICC members to implement improved patient care and support the objectives of the ICC as part of the Success regime.

i.e.

- Deliver more care outside of hospital
- Ensure an increased focus on prevention
- Ensure a more consistent approach to care planning/risk stratification
- Focus more attention on to self-care
- Improve quality through reduced clinical variation
- Establish more efficient services with less waste

Purposes for which Practice Incentive Surplus Payments may NOT be spent:

1. The purchase of services or equipment which are unconnected with healthcare.

2. To reduce a practice's contribution to the employment costs of existing practice staff.

3. The purchase of land or premises.

4. To pay off existing loans or mortgages taken out by the members of the practice, ICC or third-party landlords.

5. The purchase of drugs, medicines or appliances.

6. The purchase of hospital services.

7. Practice or ICC service premises investment where the development proposals are not consistent with the Primary Care Transformation Fund.

NHS
North Cumbria
Clinical Commissioning Group

Appendix A – Gain Share Scheme sign up

APPENDIX A

NHS NORTH CUMBRIA COMMISSIONING GROUP

AGREEMENT TO SIGN UP TO DELIVER: GAIN SHARE SCHEME

This document constitutes an agreement in principle between the practice and NHS NORTH CUMBRIA Clinical Commissioning group in regards to this Gain Share Scheme, as specified.

Name of Lead GP *(responsibility for ensuring delivery of the specification within the practice)*

……..

Signature on behalf of the Practice:

(**This must be someone in the practice with the authority to sign contracts on behalf of the practice as a provider of services and accountability for delivery of services)**

Signature	
Name	
Date	
Job title/position	
Proposed ICC (s) to work with	

Signature on behalf of the NHS North Cumbria CCG:

Signature	
Name	
Date	
Job title/position	

The agreement is to cover the twelve months commencing 1st April 2017 and ending 31st March 2018.

Please return to your Primary Care Development Officers no later than 5th May 2017.